U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 07 June 2004

In the Matter of:

VERTRUE MEADOWS

Claimant

v. CASE NO. 2003-BLA-05586

JAMB MINING, INC.,
Employer

and :

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Joseph Wolfe, Esq.
For the Claimant

Joseph W. Bowman, Esq.
For the Employer

Before: STUART A. LEVIN
Administrative Law Judge

DECISION AND ORDER

This proceeding arises from a claim for benefits under Black Lung Benefits Act, 30 U.S.C. §§ 901-945. In accordance with the Act and regulations issued thereunder, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs for a formal hearing.

Benefits under the Act are awardable to persons who are totally disabled within the meaning of the Act due to pneumoconiosis. Benefits are also awardable to the survivors of persons whose death was caused by pneumoconiosis, and for claims filed prior to January 1, 1982, to the survivors of persons who were totally disabled from pneumoconiosis at the time of the deaths. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment. It is commonly known as black lung.

A hearing was held on September 17, 2003 in Knoxville, Tennessee. Subsequent to the hearing, pursuant to an agreement reached at the hearing, Employer submitted a December 4, 2003 rereading of the chest x-ray film dated October 25, 2002 by Dr. W. Scott which is hereby entered into evidence as Employer's Exhibit 6[1].

Issues

At the hearing, Employer stated it had no information contrary to the employment records included in the Director's Exhibits. Based on those records, the Director found eighteen and three-quarter years (18 3/4) of coal mine employment had been established (DX 1, 5 – 9, 15). Although Claimant's representative stated Claimant alleged twenty-seven years (27) in coal mine employment, he also stated he would accept the Director's finding on the length of Claimant's coal mine employment (TR 11). The Director's finding on the length of Claimant's coal mine employment is well supported by the record, and I find, therefore, Claimant has established eighteen and three-quarter (18 3/4) years of coal mine employment. In addition, upon review of Claimant's employment history, I find the named Employer, Jamb Mining, Inc., is correctly identified as the Responsible Operator since Claimant last worked for Employer from 1988 through his injury in 1990. 20 CFR 725.494.

The following issues remain for resolution:

(1) Whether Claimant has pneumoconiosis;

(2) Whether Claimant's pneumoconiosis arose out of coal mine employment;

(3) Whether the Claimant is totally disabled;

(4) Whether Claimant's total disability is due to pneumoconiosis; and

(5) Whether the evidence establishes that one of the applicable conditions of entitlement has changed since the January 24, 1996, the date upon which the order denying the prior claim became final.

Background History

Claimant testified he last worked in coal mine employment in March, 1990 for Jamb Mining, Inc, the named Employer. At that time, Claimant was hurt in a mining accident. He has not worked since March, 1990 (TR 14). Claimant also testified he remains married to his wife, Gertie May White Meadows whom he married on March 8, 1969 (TR 14, DX 11). Claimant stated he has no dependent children (TR 14, DX 2). He last worked as a working foreman. Prior to that he had worked as a scoop operator, buggy operator, and general labor in the mines (DX 5).

[1] DX indicates Director's Exhibits; EX indicates Employer's Exhibits; CX indicates Claimant's Exhibits; and TR indicates the transcript of the hearing held on September 17, 2003.

Claimant filed a claim on August 25, 1995 which was denied by the District Director on January 24, 1996 because the evidence did not establish that the presence of pneumoconiosis which arose out of Claimant's coal mine employment, that he was disabled or that his disability was due to pneumoconiosis (DX 1). Claimant filed this claim for benefits on February 13, 2002 (DX 3). On October 4, 2003, the district director issued a finding that he was entitled to benefits along with a schedule for submission of additional evidence (DX 15). After considering additional evidence, on January 27, 2003, the district director issued a Proposed Decision and Order finding Claimant eligible for benefits since he had established that he had pneumoconiosis, that such pneumoconiosis arose out of coal mine employment, and that he was totally disabled due to pneumoconiosis (DX 23). The Employer requested a hearing on February 25, 2003 (DX 24) and this matter was transferred to this Office on March 14, 2003 (DX 24, 26). As noted above, a hearing was held before me on September 17, 2003 at Knoxville, Tennessee.

Presence of Pneumoconiosis

Pursuant to Section 718.202, a living miner can demonstrate the presence of pneumoconiosis by: 1) x-rays interpreted as being positive for the disease; or 2) biopsy evidence; or 3) the presumptions described in Sections 718.304, 718.305, or 718.306, if found to be applicable; or 4) a reasoned medical opinion which concluded the disease is present, if the opinion is based on objective medical evidence such as blood-gas studies, pulmonary function studies, physical examinations, and medical and work histories.

Chest X-ray Reports

EX. NO.	DOCTOR CRDNTL[2]	DATE OF X-RAY	READING
DX 1	Forehand, B	09-15-95	No pneumoconiosis
DX 1	Iosif, B	09-15-95	No pneumoconiosis
DX 1	Sargent, B/BCR	09-15-95	No pneumoconiosis
EX 1	Fino, B	08-29-02	2/3, r, u, coalescence, left upper lung
DX 14	Patel, B/BCR	09-05-02	2/2 q, q, large opacity A
DX 14	Goldstein, B	09-05-02	Quality 1
CX 1	Deponte, BCR/B	10-25-02	2/2 r, q, Large opacity A pleural thickening left chest wall probably related to prior cardiac surgery
EX 6	Scott, B/BCR	10-25-02	1/1 q, q, possible etiology is tuberculosis, fungus, sarcoid, EG, pneumoconiosis. I favor TB with areas of conglomerate disease peripherally in left upper and lower lung with adjacent thickened pleura.

[2] The symbol "B" denotes a physicians who was an approved "B-reader" at the time of the x-ray reading. A B-reader is a radiologist who has demonstrated his expertise in assessing and classifying x-ray evidence of pneumoconiosis. These physicians have been approved as proficient readers by the National Institute of occupational Safety & Health, U.S. Public Health Service pursuant to 42 C.F.R. §37.51 (1982). The symbol "BCR" denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. §727.206(b)(2)(III).

The record includes negative readings of the September, 1995 x-ray film and positive readings of the films taken in 2002. Dr. Fino concluded the changes seen on chest x-ray were not due to pneumoconiosis after reviewing the findings included in the biopsy report. Dr. Scott concluded the most likely cause of the changes on chest x-ray was tuberculosis, although he noted pneumoconiosis was a possible etiologic factor for the radiographic changes. Drs. Patel, Forehand and Deponte concluded the changes were due to pneumoconiosis. As will be discussed in detail below, I find the biopsy finding of marked anthracosis and reactive changes lends support to the positive readings by Drs. Patel, Forehand and Deponte which attributed the changes on the x-ray film to pneumoconiosis. Accordingly, I find the positive readings by Dr. Deponte, Dr. Forehand and Dr. Patel, as supported by the biopsy report, outweigh the contrary x-ray reports of record and are sufficient to establish the presence of pneumoconiosis under the provisions of subsection 718.202(a)(1).

Autopsy or Biopsy

A biopsy was performed on Claimant's lymph nodes and right lung on January 9, 2002 at the University of Tennessee Medical Center at Knoxville. Drs. R. Dieter, P. Banick, D. Keeble, M. Beard and S. Souther prepared a report regarding this biopsy. These physicians noted a clinical history of pulmonary fibrosis. The final diagnosis on biopsy was hyalinized granulomata and fibrosis and anthracosis and reactive changes in the three lymph nodes sections examined on biopsy. In the right upper lobe lung section, the physicians reported: 1) multiple hyalinized granulomata, predominantly interstitial; 2) marked anthracosis, 3) atelectasis, 4) mild interstitial inflammation, chronic, and 5) no evidence of malignancy. In the right middle lobe section, the physicians reported: 1) hyalinized granulomata; 2) anthracosis, marked; 3) no evidence of malignancy. In comments to the biopsy, the physicians stated "Multiple hyalinized granulomata are identified in the lymph nodes and lung tissue…. Anthracosis is also marked within the lymph nodes and the lung tissue." (DX 14).

On reviewing the biopsy findings, Drs. Fino and Hippensteel, both highly qualified as pulmonary specialists, found these findings did not establish the presence of pneumoconiosis. Dr. Fino stated the biopsy did not report macro nodules or micro nodules or coal macules, but only mentioned the presence of anthracosis which is merely a finding of dust in the lungs. Likewise, Dr. Hippensteel stated the findings on lung biopsy are not findings to confirm coal worker's pneumoconiosis but suggest rheumatoid pleural disease.

In contrast to the review findings of Drs. Fino and Hippensteel, however, the physicians who conducted the actual biopsy did include findings of marked anthracosis and reactive changes. The regulations state that, "A finding in an autopsy or biopsy of anthracotic pigmentation, however, shall not be sufficient, by itself, to establish the existence of pneumoconiosis." 20 CFR §718.202(a)(2). The biopsy report, however, does not report the presence of anthracotic pigmentation but rather it reports the presence of marked anthracosis and in the lymph nodes, marked anthracosis with reactive changes. The definitions of pneumoconiosis listed in the regulations includes anthracosis. 20 CFR §718.201(a)(1). In contrast to Dr. Fino's statement that "anthracosis" means merely the presence of anthracotic pigmentation, the regulations distinguish between the presence of anthracotic pigmentation and anthracosis. I find, therefore, the biopsy finding of anthracosis meets the definition of

pneumoconiosis as set forth in Section 718.201(a)(1). Under the circumstances of this case, I accord great weight to the opinions of the physicians who conducted the biopsy and who diagnosed anthracosis. I find this biopsy finding outweighed the contrary opinions of Drs. Fino and Hippensteel who reviewed the written biopsy report for the Employer. I find, therefore, the biopsy report of January 9, 2002 establishes the presence of pneumoconiosis under the provisions of subsection 718.202(a)(2).

Presumptions

Although the presumption at Section 718.304 provides a presumption of total disability due to pneumoconiosis where x-ray diagnoses yield one or more large opacity, I find that the x-ray reports in this case are not sufficient to establish complicated pneumoconiosis. In considering the x-ray reports in conjunction with the biopsy findings, it is clear that Claimant has both hyalinized granulomata, fibrosis and pneumoconiosis or anthracosis present in his lungs. What is not clear from the biopsy report, however, is whether the areas of coalescence seen on chest x-ray are due to the hyalinized granulomata or to the pneumoconiosis. Under these circumstances, I find Claimant has not submitted evidence which clearly establishes the areas of coalescence identified by several physicians on chest x-ray are large opacities of pneumoconiosis. I find, therefore, Claimant has not established the presence of pneumoconiosis by the presumption set forth at Section 718.304.

The presumption at Section 718.305 is not applicable to this claim filed after January 1, 1982 and the presumption at Section 718.306 is not applicable to this claim involving a living miner.

In conclusion, I find the Claimant has not established pneumoconiosis by the presumptions as provided in subsection 718.202(a)(3).

Medical Opinion Reports

The final way to establish the existence of pneumoconiosis under Section 718.202(a) is set forth in subparagraph (a)(4). A determination of the existence of pneumoconiosis may be made, notwithstanding a negative x-ray, if a physician exercising sound medical judgment finds the miner suffers from pneumoconiosis as defined in §718.201. Any such finding shall be based on objective medical evidence, such as arterial blood gas tests, physical performance tests, physical examinations, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion. The record includes the following medical opinion reports:

Dr. G. Iosif examined Claimant on September 15, 1995 and reported negative chest x-ray with normal results on pulmonary function study and blood gas study. Dr. Iosif conclude there was no evidence of pneumoconiosis or any pulmonary condition and/or pulmonary impairment due to Claimant's coal dust inhalation (DX 1).

On August 29, 2002, Dr. G. Fino examined Claimant. Dr. Fino reported on this examination in a report dated August 19, 2003, almost a year later. Dr. Fino reported that on his physical examination, Claimant's chest and lungs were clear to auscultation and percussion on a

tidal volume breath and forced expiration maneuver with no wheezes, rales, rhonchi or rubs. On chest x-ray, Dr. Fino reported pneumoconiosis, 2/3 r, u and coalescence in the left upper lung. On pulmonary function study, Dr. Fino stated the miner showed a combined obstructive and restrictive defect with improvement into normal values after the use of bronchodilators. On lung volume testing and diffusing capacity, Claimant demonstrated reduced values. Dr. Fino reported oxygen saturation and carboxyhemoglobin values were normal. Dr. Fino reviewed medical records. He diagnosed diffuse interstitial lung disease characterized by hyalinized granulomata on pathology. Dr. Fino stated it was his opinion these changes were not coal worker's pneumoconiosis but were due to sarcoidosis or another granulomatous disease such as tuberculosis or histoplasmosis. Dr. Fino also concluded Claimant had a combined reversible obstructive and restrictive defect.

Dr. Fino stated he agreed with Dr. Forehand that Claimant has a serious pulmonary condition and he agreed serious changes are present on chest x-ray. Based on his review of the pathology report, however, Dr. Fino concluded these are not the classic changes of coal worker's pneumoconiosis, but the hyalinized granulomata are a response of the lung to inflammation. Dr. Fino also noted Claimant's chest x-ray films were negative in 1995 and he stated it is unusual to develop pneumoconiosis six years later with such a rapid onset. Instead, Dr. Fino stated, the changes here are consistent with a disease process producing hyalinized granulomata. Dr. Fino concluded: 1) simple or legal coal worker's pneumoconiosis is not present; 2) Claimant has a disabling respiratory impairment due to granulomatous infection which did not arise from coal mine employment; and 3) Claimant would have the same disability even if he never worked in coal mine employment. Dr. Fino stated the respiratory impairment is due to a granulomatous disease or asthma-type condition (EX 1).

At a deposition taken on September 16, 2003, Dr. Fino stated he had reviewed additional medical evidence, including reports by Drs. Hippensteel and Rasmussen. Dr. Fino stated Claimant's lung volumes showed a restrictive component and his total lung capacity was reduced. Claimant's values on testing with Dr. Rasmussen were similar to values obtained by Dr. Fino. Dr. Fino agreed pneumoconiosis is progressive and can be latent, however, it was his opinion that was not the case here where Claimant ceased coal mine employment in 1990, had negative x-ray films in 1995 and then developed significant changes on chest x-ray films by 2002. Dr. Fino also stated that on biopsy no macro-nodules, micro-nodules or coal macules were reported nor was there any mention of silicotic nodules. Dr. Fino stated the finding of anthracosis means only that dust is present in the lungs. Dr. Fino also stated the multiple hyalinized granulomata present are due to an inflammatory process such as sarcoidosis or rheumatoid arthritis. Dr. Fino did agree, however, that granulomatous disease and coal worker's pneumoconiosis could occur at the same time and he also agreed the biopsy report did not diagnose rheumatoid arthritis. Dr. Fino stated, however, it was his opinion the biopsy report did rule out coal dust as the causative factor for many of the rounded and irregular opacities seen on chest x-ray (EX 5).

On September 5, 2002, Dr. R. Forehand examined Claimant and reported normal configuration on inspection, no tenderness to palpation, no dullness to percussion, and diminished breath sounds with crackles at the lung bases on auscultation. On chest x-ray, Dr. Forehand reported the presence of complicated pneumoconiosis, 2/2 q, q, with category A

opacity. On pulmonary function study, Dr. Forehand reported an obstructive ventilatory pattern was demonstrated and on blood gas study he reported no hypoxemia at rest or with exercise and no metabolic disturbances. On electrocardiogram testing, Dr. Forehand reported no acute changes. Dr. Forehand diagnosed complicated coal worker's pneumoconiosis based on Claimant's history of coal mine employment, physical examination findings and chest x-ray. Dr. Forehand stated this condition was due to Claimant's coal dust exposure in coal mine employment. Dr. Forehand also concluded that Claimant is totally disabled with evidence of serious injury to his lung parenchyma. Dr. Forehand stated coal worker's pneumoconiosis is the sole factor contributing to his respiratory impairment (DX 14).

Dr. D. Rasmussen examined Claimant on March 13, 2003. Dr. Rasmussen reported chest expansion and diaphragmatic excursions were normal with minimally reduced breath sounds and transient rhonchi. Dr. Rasmussen reported chest x-ray, as read by Dr. M. Patel, a board certified radiologist and B-reader, was positive for pneumoconiosis, 3/2 q, q, with a category A opacity. On electrocardiogram testing, Dr. Rasmussen reported sinus tachycardia, poor R-wave progression, low amplitude, RI consistent with prior anterior myocardial infarction. Dr. Rasmussen reported pulmonary function study results showed minimal irreversible obstructive ventilatory impairment and maximum breathing capacity was moderately reduced. Claimant's single breath carbon monoxide and diffusing capacity values were normal. In addition resting blood gas studies were normal and oxygen transfer on exercise was normal with no evidence of hypoxia. Dr. Rasmussen concluded Claimant would be unable to perform heavy manual labor. He stated it is medically reasonable to conclude Claimant has coal worker's pneumoconiosis due to coal mine employment based on his significant coal mine employment history and the chest x-ray findings. Dr. Rasmussen noted Claimant has a minimal smoking history and, thus, he concluded Claimant's coal mine dust exposure is a major contributing factor to his loss of lung function (CX 3).

Dr. K. Hippensteel examined Claimant on August 27, 2003, and reported mild kyphosis with increased AP diameter of the chest and sparse rales in the bases of the lung with no wheezes. On pulmonary function study, Dr. Hippensteel reported upper airway collapse on forced expiration possibly from bronchomalacia or volition adding to airflow limitation. On chest x-ray, Dr. Hippensteel reported pneumoconiosis, 2/2 s, q with evidence of areas of coalescence in multiple places but no distinct large opacities. Dr. Hippensteel also reported bilateral pleural thickening and blunted left costrophrenic angle, not related to coal worker's pneumoconiosis but which could be related to rheumatoid arthritis. Dr. Hippensteel stated the parenchymal findings are not typical for coal worker's pneumoconiosis. On electrocardiogram testing, Dr. Hippensteel reported bilateral enlargement with low voltage front leads and poor R wave progression possibly from an old anterior infarction. On spirometry, Dr. Hippensteel reported no obstruction before or after the use of bronchodilators. The MVV was severely reduced which was due to varied effort and, therefore, is invalid. The lung volume showed evidence of a mild restriction and diffusion was markedly reduced which could be due to suboptimal inhaled volume. Dr. Hippensteel reported blood gas study showed normal gas exchange at rest. The data showed evidence of rheumatoid arthritis, rheumatoid pleural disease and probable rheumatoid lung disease. Dr. Hippensteel stated these findings do not rule out coal worker's pneumoconiosis, but the changes present in this case are not typical for coal worker's pneumoconiosis. Dr. Hippensteel reviewed other medical reports. He felt it was error for Dr.

Rasmussen to fail to consider rheumatoid arthritis and he disagreed with Dr. Rasmussen's finding that Claimant was permanently disabled based on a minimal loss of lung function. Dr. Hippensteel also stated Dr. Forehand disregarded the rheumatoid lung disease. On review of the pathology report, he stated the hyalinization reported is commonly found in rheumatoid lung disease and he noted the marked anthracosis was present with no evidence of malignancy or coal dust macules.

Dr. Hippensteel concluded the rapid change in the chest x-ray findings is not consistent with coal worker's pneumoconiosis which usually advances one category every five years. The rapid changes seen are more consistent with rheumatoid lung disease. He also stated coal dust macules are required to diagnose coal worker's pneumoconiosis and he noted no restrictive disease was present on pulmonary function study. In addition, Dr. Hippensteel noted the normal blood gas study results demonstrated Claimant has no impairment in gas exchange. Dr. Hippensteel stated Claimant developed rheumatoid arthritis with rheumatoid pneumonitis after the negative chest x-ray films in 1995. The lung biopsy findings do not confirm coal worker's pneumoconiosis but suggest that rheumatoid lung disease associated with rheumatoid pleural disease is present. Dr. Hippensteel stated, however, Claimant has no permanent pulmonary impairment from any cause, so even if coal worker's pneumoconiosis is present, he is not impaired due to any pulmonary cause. Thus, Dr. Hippensteel concluded, Claimant has the respiratory capacity to do his usual coal mine employment (EX 3).

All physicians agreed that Claimant has some changes in his lungs and in his pulmonary condition. Drs. Forehand and Rasmussen diagnose coal worker's pneumoconiosis while Drs. Fino and Hippensteel conclude the changes are not coal worker's pneumoconiosis but are either sarcoidosis, other granulomatous diseases such as tuberculosis or rheumatoid lung disease related to the development of rheumatoid arthritis. Drs. Fino and Hippensteel reach their diagnoses, in part, on their conclusion that the biopsy report does not establish the presence of pneumoconiosis and, therefore, the changes seen on chest x-ray are not due to pneumoconiosis. However, as noted above, the clear language of the biopsy report indicates two conditions are present, marked anthracosis with reactive changes and hyalinized granulomata and fibrosis. Thus, the findings of the biopsy report support a finding that the chest x-ray changes are due to two conditions, anthracosis and some other condition. Dr. Hippensteel criticizes the reports of Drs. Forehand and Rasmussen for failing to consider possible rheumatoid arthritis and rheumatoid lung disease. Dr. Hippensteel, however, states that coal dust macules are required to diagnose coal worker's pneumoconiosis, but he fails to discuss the fact that the biopsy report concluded anthracosis (not just anthracotic pigmentation) was present with reactive changes. Dr. Fino did agree at his deposition that a granulomatous disease and coal worker's pneumoconiosis could occur at the same time and he further agreed the biopsy report did not diagnose rheumatoid arthritis so that the hyalinized changes noted could be due to some other condition.

Under these circumstances, I find the biopsy report supports the findings of Drs. Forehand and Rasmussen that coal worker's pneumoconiosis is present. The biopsy report, the fact that the chest x-ray readings were negative in 1995, and the discussion by Drs. Fino and Hippensteel of the fact that such a rapid progression in changes on chest x-ray is not consistent with coal worker's pneumoconiosis does support a finding that the changes present on x-ray are not due solely to coal worker's pneumoconiosis but are also due to some other cause. This

finding that another pulmonary condition progressed rapidly from 1995 through 2002, however, does not rule out the presence of pneumoconiosis on the chest x-ray films in 2002 especially in light of the findings on the biopsy report.

Therefore, I find the evidence establishes the presence of pneumoconiosis under the provisions of Section 727.203(a)(1), (a)(2) and (a)(4). Since Claimant has established the presence of pneumoconiosis, one of the applicable conditions of entitlement, this claim for benefits shall not be denied on the basis of the prior denial as set forth in Section 725.309(d).

Establishing Causal Relationship

In addition, in order for a claimant to be found eligible for benefits under the Act, it must be determined that the miner's pneumoconiosis arose at least in part out of coal mine employment. If a miner who is suffering from pneumoconiosis was employed more than ten years in coal mine employment, there shall a rebuttable presumption that such pneumoconiosis arose out of such employment. 20 C.F.R. 718.203(b). The evidence establishes Claimant worked eighteen and three-quarter (18 3/4) years in coal mine employment. Thus, the rebuttable presumption set forth at Section 718.203(b) is applicable to his claim. There is no evidence of record which concludes that Claimant's pneumoconiosis was due to any cause other than his coal mine employment. Although Drs. Fino and Hippensteel attributed the changes on Claimant's chest x-ray to other causes and not to coal worker's pneumoconiosis, their findings are outweighed by the contrary x-ray reports and medical opinion reports as supported by the biopsy report as set forth above. Furthermore, they did not find that Claimant's pneumoconiosis arose from any cause other than coal mine employment. Therefore, I find the presumption is not rebutted and I find that Claimant has established his pneumoconiosis arose out of his coal mine employment.

Total Disability

The determination of the existence of a totally disabling respiratory or pulmonary impairment shall be made under the provisions of Section 718.204. A claimant shall be considered totally disabled if the irrebuttable presumption of Section 718.304 applies to his claim. If the irrebuttable presumption does not apply, a miner shall be considered totally disabled if he is prevented from performing his usual coal mine work or comparable and gainful work. In the absence of contrary probative evidence, evidence which meets one of the Section 718.204(b)(2) standards shall establish the claimant's total disability. According to Section 718.204(b)(2), the criteria to be applied in determining total disability include: 1) pulmonary function studies, 2) arterial blood gas tests, 3) a cor pulmonale diagnosis and 4) a reasoned medical opinion concluding total disability.

The physicians who read the 2002 and 2003 x-ray films noted the presence of coalescence or category A opacities. Some physicians attributed these changes to complicated pneumoconiosis and other physicians attributed these changes to coalescence from rheumatoid lung disease. The biopsy report noted multiple hyalinized granulomata and marked anthracosis. The biopsy report did not clearly attribute the coalescence or large opacities to either of these findings. Accordingly, I find the medical opinions regarding these changes on chest x-ray to be

equally probative. Since the evidence is evenly divided, Claimant has not established that the changes on x-ray film are large opacities due to pneumoconiosis. Under such circumstances, when the evidence is evenly balanced, the benefits claimant must lose since he bears the burden of persuasion. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 11 S.Ct. 2251 (1994). Therefore, the irrebuttable presumption of Section 718.304 is not applicable to his claim.

Pulmonary Function Studies

Pulmonary function study results were submitted for evaluation on the issue of total disability under Section 718.204(b)(2)(i). Assessment of these results is dependent on Claimant's height which was recorded as sixty-seven inches. The pulmonary function study results are summarized in the table below:

EX. NO.	PHYSICIAN	DATE	AGE	FEV_1	FVC	FEV_1 FVC	MVV
DX 1	Iosif	09-15-95	49	2.95	3.66	---	---
EX 1	Fino	09-29-02	56	2.07	2.90	71%	---
				2.44	3.51	69%	---
DX 14	Forehand	09-05-02	56	2.45	3.57	69%	68
CX 3	Rasmussen	03-13-03	56	2.36	3.52	67%	80
				2.55	3.55	72%	93
EX 3	Hippensteel	08-19-03	56	1.71	2.11	81%	51
				1.86	2.41	77%	---

Dr. Hippensteel noted variable effort on the pulmonary function study he conducted with poor effort on the MVV maneuver and, thus, I accord less weight to the results of the August, 2003 pulmonary function study. Claimant's values on the other four tests do not qualify under the regulations. Since none of the valid studies produced qualifying results, Claimant has not established total disability under the provisions of subsection 718.204(b)(2)(i).

Arterial Blood Gas Studies

Three arterial blood gas studies were also submitted for evaluation of total disability under Section 718.204(b)(2)(ii). Total disability may be established with arterial blood gas tests which produce values less than or equal to the qualifying values listed in Appendix C to 20 C.F.R. §718. The arterial blood gas test results are summarized in the table below:

EX. NO.	DATE	DOCTOR	pCO_2	pO_2
DX 1	09-15-1995	Iosif	26.8	80.5
EX 1	08-29-2002	Fino	39.9	82.1
DX 14	09-05-2002	Forehand	26.0 28.0	76.0 (at rest) 78.0 (after exercise)
CX 3	03-13-2003	Rasmussen	26.0 26.0	81.0 (at rest) 86.0 (after exercise)
EX 3	08-19-2003	Hippensteel	30.0	82.7

Claimant's values on all the blood gas studies are non-qualifying under the regulations. Therefore, I find the blood gas study results do not establish that Claimant is totally disabled under the provisions of subsection 718.204(b)(2)(ii).

Cor Pulmonale

A claimant may also establish total disability by providing medical evidence of cor pulmonale with right-sided congestive heart failure pursuant to Section 718.204(b)(2)(iii). As no medical evidence of cor pulmonale was admitted into the record, I find the Claimant failed to establish total disability with medical evidence of cor pulmonale.

Medical Opinions

The remaining means of establishing a totally disabling respiratory or pulmonary impairment under Section 718.204(b)(2) is with a reasoned medical opinion which concludes total disability is present, if the opinion is based on medically acceptable clinical and laboratory diagnostic techniques. A claimant must demonstrate that his respiratory or pulmonary condition prevents him from engaging in his "usual" coal mine employment or comparable and gainful employment". 20 C.F.R. §718.204(b)(2)(iv). The medical opinion reports are set forth above. In summary, Dr. Iosif found no pulmonary impairment in 1995, Dr. Fino concluded Claimant was disabled by his respiratory or pulmonary impairment which he attributed to granulomatous infection or asthma type condition in August, 2002, Dr. Forehand concluded Claimant was totally disabled with evidence of serious injury to his lung parenchyma in September, 2002, Dr. Rasmussen concluded Claimant was unable to perform heavy manual labor due to his loss of lung function due to coal mine dust exposure in March, 2003, and Dr. Hippensteel concluded Claimant has no restrictive disease no impairment in the exchange of gases, and no permanent pulmonary impairment from any cause in August, 2003.

Dr. Forehand and Dr. Rasmussen did not discuss the basis for their conclusions that Claimant was totally disabled in light of their own pulmonary test results which were non-qualifying under the regulations. Dr. Fino noted restrictive component was demonstrated on

lung volume testing and total lung capacity was reduced in support of his finding that Claimant was disabled by his respiratory or pulmonary impairment. Dr. Hippensteel also cited results of pulmonary testing, however, in support of his conclusion that Claimant had no pulmonary impairment from any cause and retains the respiratory capacity to do his usual coal mine employment.

Upon considering the medical opinion reports, I find Dr. Hippensteel's report most persuasive regarding Claimant's pulmonary capacity. Dr. Hippensteel's opinion is well supported by the pulmonary test results. Dr. Fino also relies upon the results of lung volume testing and total lung capacity testing in his report; however, he does not discuss why these results are more persuasive than the normal results demonstrated by Claimant on pulmonary function study and blood gas study which were relied upon by Dr. Hippensteel. Under these circumstances, I find Dr. Hippensteel's conclusion on Claimant's pulmonary capacity better supported since his conclusion is well supported by the non-qualifying test results of record. Accordingly, I find the probative weight of the medical opinion reports does not establish total disability due to pneumoconiosis under the provisions of subsection 718.204(b)(2)(iv).

On consideration of all of the evidence of record, I find that the non-qualifying pulmonary function studies, the non-qualifying blood gas studies and the medical opinion reports of record all fail to establish total disability due to pneumoconiosis. Thus, I find Claimant has not established total disability under the provisions of subsection 718.204(b)(2).

Entitlement

In conclusion, Claimant has established the presence of pneumoconiosis and, therefore, this claim shall not be denied on the basis of the prior denial under the provisions of Section 725.309(d). Claimant has not, however, established that he is totally disabled due to pneumoconiosis and, thus, he is not entitled to benefits and this claim for benefits shall be denied.

ORDER

The claim of Vertrue Meadows for benefits under the Act shall be **DENIED**.

A

STUART A. LEVIN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20018-7601. A copy of this notice must also be served on Donald S. Shire, Associate Solicitor, Room N-2605, 200 Constitution Avenue, N.W., Washington, D.C.